CHAPTER III: PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION FACILITIES BILLING INFORMATION

OBJECTIVE

This chapter provides participants with pertinent billing information related to the prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital. It highlights the new requirements as well as reviews some of the requirements that have not been affected.

IRF PPS IMPLEMENTATION SCHEDULE

Implementation

- **The First Day of the Cost Reporting Period that Begins on or After January 1, 2002**

Providers will transition to the IRF PPS on the first day of the cost reporting period that begins on or after January 1, 2002.

IRF PPS coding is applicable for Medicare Part A fee-for-service inpatient rehabilitation services for discharges beginning on or after the provider has transitioned to the IRF PPS.

BILLING REQUIREMENTS UNCHANGED BY THE IMPLEMENTATION OF THE IRF PPS

Unchanged Requirements

- **Provider Classification**
- **Bill Types**
- **Ancillary Services**
- **Leave of Absence**
- **Adjustments**
  - **Changes to HIPPS Codes are Allowed**
- **Timeliness Standards**
- **FI/CWF Processing**

In general, the criteria for a facility to be classified as an IRF remains unchanged from the requirements used to classify entities as exempt from the acute care hospital PPS. Therefore, claims can only be submitted for payment under IRF PPS for institutional providers where the provider number has a "T" as the third digit (XXTXXX) or where the last four digits of the provider number are in the 3025 – 3099 range (XX3025 – XX3099).

IRF claims should be submitted on a 11X type of bill.

Claims are to be prepared using established guidelines for general coding. This includes, but is not limited to the guidelines for ancillary services, leave of absence situations, and Medicare Secondary Payer (MSP) situations.

Claim adjustments can be submitted using established guidelines. A 117 type of bill is used for adjustments, while a 118 type of bill is used for cancels. IRF claims can be adjusted to change the Health Insurance Prospective Payment System (HIPPS) code using adjustment reason code D4. However, the corrected HIPPS code must be verifiable using the patient's medical records and/or documentation.

Claims must be submitted to the FI in a timely manner. For dates of service January 1 – September 30, the timely filing limit is December 31 of the following year. For dates of service October 1 to December 31, the timely filing limit is December 31 of the second year following the date of service. For example:

- If the date of service is sometime between January 1, 2002 and September 30, 2002, the claim must be submitted to the FI by December 31, 2003

- If the date of service is between October 1, 2002 and December 31, 2002, the claim must be submitted to the FI by December 31, 2004

Claims must be submitted to the FI for processing and will be subject to various claims processing edits. Once processed by the FI, claims will be sent to Common Working File (CWF) for additional edits and posting in the beneficiary's national Medicare record.

NEW BILLING REQUIREMENTS CREATED BY THE IMPLEMENTATION OF THE IRF PPS

Claim Length

New Requirement

- **IRF Providers Submit Only One Claim for an Entire Inpatient Stay, Including Interrupted Stays**

After the implementation of the IRF PPS, providers should submit only one claim for an entire inpatient stay. However, 60-day interim bills will be allowed.

One claim should be submitted when there has been an interrupted stay. If a provider has submitted two separate claims, the second claim will need to be cancelled and the first claim will need to be adjusted to add on the interruption and the second stay.

- Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within three consecutive calendar days.

Type of Bill

Interim billing is allowed for non-PIP providers with the use of Types of Bill 112 and 117. Sequential billing is not allowed (Types of Bill 113 and 114) for any IRF provider.

Late charge claims (Type of Bill 115) are not permitted.

If a provider has late charges to add to a claim, an adjustment bill (Type of Bill 117) must be submitted.

Revenue Code 0024

New Revenue Code (0024)

- **Use with HIPPS Code**
- **Do Not Indicate Days in the Units Field**
- **Do Not Indicate Charges**
- **Use Only Once per Claim**

Revenue code 0024 has been created to indicate that a provider is billing under IRF PPS. The use of revenue code 0024 will signal the FI's claims processing system to use the FI's IRF PPS pricer software in order to determine the provider's reimbursement.

The revenue code should be used in conjunction with a HIPPS code in the HCPCS/Rate field. Units entered on the 0024 must be accepted, but are not required. Covered Charges, FL47, (RT60, field 10), (SV203), should contain zero covered charges when the revenue code is 0024.

Units are not listed under revenue code 0024 since payment is not made based on the number of days utilized. Charges and days should still be listed with the appropriate accommodation revenue code line (010X – 021X).

Only one revenue code 0024 line is necessary and allowed on a claim.

HIPPS Codes

HIPPS Codes

- **Only One Reported per Claim**
- **Constructed Using Comorbidity Tier and CMG Codes**

The Health Insurance Prospective Payment System (HIPPS) code is five digits in length and is placed on the claim in the HCPCS/Rates field. Only one HIPPS code is allowed on a claim.

The combination of two other codes, the Comorbidity code and the Case Mix Group (CMG), determine the HIPPS code.

The HIPPS code is constructed by using the patient's comorbidity tier for the first digit and the four-digit Case Mix Group (CMG) code for the other four digits.

The following is an explanation of a typical HIPPS code:

- **Example**:

  Patient has a stroke and is assessed with a motor score of 34-38. Patient is 82 years old or younger with no comorbidities.

  Since the patient cannot be classified into one of the comorbidity tiers, the first character of the HIPPS code will be A.

  The next four characters equal the CMG from the assessment, which in this case is 0109.

  The HIPPS Code billed would be A0109.

Comorbidity

Comorbidity

- **Based on whether costs are high, medium, or low**
- **Four codes--A, B, C, and D**

The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

There are four comorbidity codes. Each one relates to the tier in which the ICD-9-CM code falls. The four codes are:

- A = without comorbidities
- B = comorbidity in tier 1
- C = comorbidity in tier 2
- D = comorbidity in tier 3

The ICD-9-CM codes and their respective comorbidity tiers can be found in Appendix C.

Case Mix Groups (CMGs)

Case Mix Groups (CMGs)

- **Based on the Clinical Characteristics of the Medicare Beneficiary**
- **100 CMGs Total**

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. The Final Rule used Rehabilitation Impairment Categories (RICs), functional measurements, and age to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. In addition to the RICs, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age also allows CMS to improve the explanatory power of the CMGs; some of the groups are based on this variable.

CMGs Each Have a Separate Payment Rate Which May be Adjusted by:

- **Comorbidities**
- **Case-Level Adjustments**
- **Outliers**
- **Payment for CMGs Will be Adjusted for Facility Characteristics**

There are five CMGs that are assigned by the Pricer in "special" situations and 95 CMGs that are related to the patient's condition, for a total of 100 CMGs. There is a total of 380 possible HIPPS codes that a provider can bill, factoring in the four comorbidity tiers for the "regular" CMGs. Providers will never key a claim with any of the five "special" CMGs (A5001, A5101, A5102, A5103 or A5104).

Each CMG has a separate reimbursement rate, which can be different for each patient and each stay due to various factors. These factors include case-level adjustments, facility-level adjustments and outlier payments, as well as an adjustment due to patient comorbidities.

The CMG codes are located in Chart 6 of the *Federal Register*, page 41345.

New Patient Status Codes

New Patient Status Codes

- **62-Discharged to Another IRF**
- **63-Discharged to a Long-Term Care Hospital**

Program Memorandum A-01-86, published July 24, 2001, introduced two new patient status codes to indicate when a patient is discharged to another rehabilitation facility (patient status 62) or a long-term care hospital (patient status 63). These new patient status codes will be effective as of January 1, 2002.

These two new codes are in addition to the existing discharge patient status codes. Accurately using patient status codes is important, as it affects reimbursement of the IRF claim.

SUMMARY OF FIELDS ON IRF PPS CLAIMS

- 11X Type of Bill
- Provider Information
- Patient Information
- Dates of Service
- Utilization Days (as appropriate)
  - Covered and/or non-covered days
  - Full and/or coinsurance days
- Admission Date
- Admission Type
- Admission Source
- Patient Status
- Condition Codes (as appropriate)
- Occurrence Codes (as appropriate)
- Occurrence Span Codes/Dates (as appropriate)
- Value Codes (as appropriate)
- Revenue Code Field, HCPCS/Rates Field, Units Field and Charge Fields
  - Revenue Code 0024
    - HIPPS code placed in the HCPCS/Rates field
    - Nothing is listed in the covered units/total units field
    - No charges are listed in the covered charges or non-covered charges fields
  - Accommodation Revenue Code (010X – 021X) with appropriate number of days and charges
    - If applicable, Leave of absence/ interrupted stay code (018X) with appropriate number of days, no charges are listed
  - Ancillary revenue codes with applicable units and charges

- Payer, Insured and Employer Information
- Diagnosis Codes
- Procedure Codes (as applicable)
- Physician Information
- Remarks (if needed)

A sample claim is on the next page.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Inpatient Rehabilitation Facility (IRF) *Address* *City, State Zip*	***SAMPLE CLAIM*** ***REGULAR IRF PPS BILLING***		*111*

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	02/01/02	*02/21/02*	*20*				

12 PATIENT NAME	13 PATIENT ADDRESS
John Brokmahback	*100 Main Street, Anytown, USA*

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02/14/1930	*M*	*M*	*02/01/02*	*10*	*3*	*4*	*9*	*01*	*987654321*	*C5*							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A B C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
		a b c d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0024	*Osteoarthritis with motor score from 48-54, no comorbidity*	*A1203*					
0128	*Room & Board*	*1000.00*		*20*	*20000.00*		
	+ Ancillary Revenue Codes & Charges						
0001	*Total Charges*				*XXXX.XX*		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	*XXTXXX*					

57	*DUE FROM PATIENT*

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
John Brokmahback	*01*	*123-45-6789A*		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
71515									*71515*		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID
A12345 DOCTOR, G. IMA
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
SAMPLE CLAIM - IRF PPS BILLING	X Signature	Date

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

SPECIAL BILLING SITUATIONS

Interrupted Stays

Interrupted Stays

- **Patient Discharged and Readmitted to the Same IRF Within Three Consecutive Calendar Days**
- **Both Stays are Combined on One Claim**

An interrupted stay is defined as a situation where the patient is discharged and is readmitted to the same IRF within three consecutive calendar days. The date of discharge is counted as Day 1 and the patient must be readmitted by midnight of the third day.

The two stays are to be combined on one claim and will receive one payment based on the initial stay admission assessment CMG and the patient's comorbidity tier.

To bill a claim with an interrupted stay:

- Payable days go in the covered days field
- Interruption days go in the non-covered days field
- Total days of service on the claim must be the sum of the number of payable days plus interruption days plus leave of absence days plus non-covered level of care days
    - Remember that the second date of discharge does not count toward utilization, and the first date of discharge is counted as an interruption/absence day
- Occurrence span code 74 is placed on the claim with the dates of the interruption for interruptions of more than one calendar day
    - List dates where patient was not present at midnight.
- Revenue code 0024
    - HIPPS code as constructed from patient's comorbidity tier and CMG code
    - Nothing is listed in the covered units/total units field
    - Do not list charges in covered or non-covered fields

Billing Interrupted Stays

- **Report Payable Days as Covered Days and Span Code 74 days as Non-covered**
- **Occurrence Span Code 74**
- **Revenue Code 0024**
- **Revenue Code 018X**
- **Revenue Code 010X – 021X**

- Use Revenue code 018X to indicate absence/ interruption days reflected in Occurrence span code 74
  - No code or charges in HCPCS/Rates field for Revenue code 018X
  - Units equal the number of days reflected in Occurrence span code 74
  - Do not list charges in covered or non-covered fields for Revenue code 018X
- Accommodation revenue code 010X – 021X
  - Daily room rate in HCPCS/Rates field
  - Total number of payable and non-covered days for this accommodation code (do not list interruption days or leave of absence days as "non-covered" on this line)
  - Charges must equal daily room rate multiplied by number of payable days
- Remainder of claim should have appropriate coding as required, including ancillary revenue codes and charges
    - **Examples** –
      - Interruption of one calendar day
        - Patient was discharged April 2, 2002 and was readmitted by midnight on the same day (April 2, 2002)
        - Code one claim for both stays, only one payment will be made
        - No Occurrence span code 74 is needed
        - No Revenue code 018X is needed
      - Interruption of two calendar days
        - Patient was discharged April 2, 2002 and was readmitted by midnight on April 3, 2002
        - Code one claim for both stays, only one payment will be made

  - Code the claim using occurrence span code 74, with span “from date” 04/02/02 and span “through date” 04/02/02 because the patient was not in the facility on April 2, 2001
  - Code the claim using revenue code 018X with one unit

- Interruption of three calendar days
  - Patient was discharged April 2, 2002 and was readmitted by midnight on April 4, 2002
  - Code one claim for both stays, only one payment will be made
  - Code the claim using occurrence span code 74, with span “from date” 04/02/02 and span “through date” 04/03/02 because the patient was not in the facility on April 3, 2001.
  - Code the claim using revenue code 018X with two units
- Interruption of four (or more) calendar days, Is NOT an Interrupted Stay
  - Patient was discharged April 2, 2002 and was readmitted by midnight on April 5, 2002 or any time thereafter
  - This example is not classified as an interrupted stay, since this was an absence of four days (April 2, April 3, April 4 & April 5)
  - Two separate claims will be billed and two payments made

Sample claims are on the next three pages.

1	2		3 PATIENT CONTROL NO.	4 TYPE OF BILL
Inpatient Rehabilitation Facility (IRF) *Address* *City, State Zip*	***IRF PPS CLAIM SAMPLE -*** *INTERRUPTED STAY (1 DAY)*			*111*

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	04/01/02	*04/28/02*	*27*				

12 PATIENT NAME	13 PATIENT ADDRESS
John Brokmahback	*100 Main Street, Anytown, USA*

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02/14/1930	*M*	*M*	*04/01/02*	*10*	*3*	*4*	*9*	*01*	*987654321*	*C5*							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A B C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a b c d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0024	*Osteoarthritis with motor score from 48-54, Comorbidity Tier 2*	*C1203*					
0128	*Room & Board*	*1000.00*		*27*	*27000.00*		
	PLUS Ancillary Revenue Codes and Charges						
0001	*Total Charges*				*XXXX.XX*		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	*XXTXXX*					

57	DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
John Brokmahback	*01*	*123-45-6789A*		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
71515	*0380*								*71515*		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID
A12345 DOCTOR, G. IMA
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
IRF PPS CLAIM SAMPLE – INTERRUPTED STAY (1 DAY)	*x* Signature	Date

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Inpatient Rehabilitation Facility (IRF) *Address* *City, State Zip*	***IRF PPS CLAIM SAMPLE -*** *INTERRUPTED STAY (2 DAYS)*		*111*

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	04/01/02	*04/28/02*	*26*	*1*			

12 PATIENT NAME	13 PATIENT ADDRESS
John Brokmahback	*100 Main Street, Anytown, USA*

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02/14/1930	*M*	*M*	*04/01/02*	*10*	*3*	*4*	*9*	*01*	*987654321*	*C5*							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								74	*04/02/02*	*04/02/02*	A B C

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a b c d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0024	*Osteoarthritis with motor score from 48-54, Comorbidity Tier 2*	*C1203*					
0128	*Room & Board*	*1000.00*		*26*	*26000.00*		
0180	*Interrupted Stay*			*1*			
	PLUS Ancillary Revenue Codes and Charges						
0001	*Total Charges*				*XXXX.XX*		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	*XXTXXX*					

57	DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
John Brokmahback	*01*	*123-45-6789A*		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
71515	*0380*								*71515*		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID
A12345 DOCTOR, G. IMA
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS
IRF PPS CLAIM SAMPLE – INTERRUPTED STAY (2 DAYS)

85 PROVIDER REPRESENTATIVE	86 DATE
x Signature	Date

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

1 Inpatient Rehabilitation Facility (IRF) Address City, State Zip	2 **IRF PPS CLAIM SAMPLE -** INTERRUPTED STAY (3 DAYS)						3 PATIENT CONTROL NO.	4 TYPE OF BILL 111
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11	
	04/01/02	04/28/02	25	2				

12 PATIENT NAME	13 PATIENT ADDRESS
John Brokmahback	100 Main Street, Anytown, USA

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02/14/1930	M	M	04/01/02	10	3	4	9	01	987654321	C5							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								74	04/02/02	04/03/02	A B C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a b c d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0024	Osteoarthritis with motor score from 48-54, Comorbidity Tier 2	C1203					
0128	Room & Board	1000.00		25	25000.00		
0180	Interrupted Stay			2			
	PLUS Ancillary Revenue Codes and Charges						
0001	Total Charges				XXXX.XX		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	XXTXXX					

57	DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
John Brokmahback	01	123-45-6789A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
71515	0380								71515		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID
A12345 DOCTOR, G. IMA
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
IRF PPS CLAIM SAMPLE – INTERRUPTED STAY (3 DAYS)	X Signature	Date

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

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Early Transfers

Early Transfers

- **Length of Stay is Less Than Average for Patient's Assigned CMG**
- **The Patient is Transferred Using Patient Status Code 02, 03, 61, 62, or 63**

An early transfer is where the length of stay is less than average for the patient's assigned CMG and the patient is transferred:

- to a short-term (acute care) general hospital as indicated on the claim by Patient Status 02,

- to a nursing home that accepts payment under Medicare, Medicaid or both as indicated on the claim by Patient Status 03,

NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use Patient Status 03, discharged/ transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code Patient Status 04, discharged/ transferred to an ICF, until such time that a new Patient Status code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. Patient Status 04 does not constitute a transfer under the IRF PPS policy.

- within this institution to a hospital-based Medicare-approved swing bed as indicated on the claim by Patient Status 61,

- to another rehabilitation facility as indicated on the claim by Patient Status 62, or

- to a long-term care hospital as indicated on the claim by Patient Status 63.

The early transfers do not include discharges where the patient will receive aftercare via home health services or outpatient therapy services.

No special coding, other than IRF PPS coding and the appropriate patient status code, is required on an early transfer claim.

Benefits Exhausted During Stay

Benefits Exhausted During Stay

- **Use IRF PPS Coding Plus Occurrence Code 47 and Either A3, B3 or C3**

If at least one day is remaining in the patient's current benefit period upon admission and the patient meets the criteria for skilled care under Medicare, the provider will be paid the full CMG payment.

To bill a claim where benefits exhaust during the stay:

- Use type of bill 11X
- Report covered and non-covered days
- Use occurrence code A3, B3 or C3 as appropriate with the date benefits exhausted
- Occurrence code 47 is reported with the date of the first day after the cost outlier threshold was met
    - The standardized outlier threshold amount for IRF PPS claims is $11,211.00
- Report revenue code 0024 with the following information:
    - HIPPS code as constructed from patient's Comorbidity Tier and CMG code
    - No charges in the covered or non-covered fields or units in covered units/total units field
- Report the accommodation revenue code(s) and ancillary charges with their respective covered units and charges
- Remainder of claim is coded using existing requirements

A sample claim is on the next page.

1 Inpatient Rehabilitation Facility (IRF) Address City, State Zip	2 **IRF PPS CLAIM SAMPLE -** COST OUTLIER WITH BENEFITS EXHAUST	3 PATIENT CONTROL NO.	4 TYPE OF BILL 111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	02/01/02	04/12/02	69	1	5	60	

12 PATIENT NAME	13 PATIENT ADDRESS
John Brokmahback	100 Main Street, Anytown, USA

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02/14/1930	M	M	02/01/02	10	3	4	9	01	987654321	C5							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
47	02/10/02	A3	04/10/02								A B C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	09	XXXX.XX	08	XXXX.XX		
	b						
	c						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0024	Burns w/motor score from 46-54, no comorbidity	A2101					
0128	Room & Board	1000.00		70	70000.00	1000.00	
	PLUS Ancillary Revenue Codes and Charges						
0001	Total Charges				XXXX.XX	XXXX.XX	

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	XXTXXX					
57	DUE FROM PATIENT					

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
John Brokmahback	01	123-45-6789A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
94830									94830		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID
A12345 DOCTOR, G. IMA
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS

IRF PPS CLAIM SAMPLE – COST OUTLIER WITH BENEFITS EXHAUST DURING STAY

85 PROVIDER REPRESENTATIVE	86 DATE
x Signature	Date

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

Benefits Exhausted Prior To Stay

Benefits Exhausted Prior to Stay

- **Basically the Same Requirements as Prior to IRF PPS With the Addition of the Revenue Code 0024 and HIPPS Code**

When a patient does not have any benefits remaining in his/her benefit period and he/she is at a Medicare covered level of care, a claim needs to be submitted to Medicare in order to properly document the continuation of the benefit period.
To bill a claim where benefits exhaust prior to the stay:

- Use TOB 11X
- Report all non-covered days
- Report revenue code 0024 with the following:
    - HIPPS code as constructed from patient's comorbidity tier and CMG code
    - No charges reported in either the covered or non-covered fields; no units listed in the covered units/total units field
- Report any services that can be billed under the Part B benefit using 12X TOB

A sample claim is on the next page.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Inpatient Rehabilitation Facility (IRF) *Address* *City, State Zip*	***IRF PPS CLAIM SAMPLE -*** *BENEFITS EXHAUSTED PRIOR TO STAY*		*110*

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	02/01/02	*02/21/02*		*20*			

12 PATIENT NAME	13 PATIENT ADDRESS
John Brokmahback	*100 Main Street, Anytown, USA*

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02/14/1930	*M*	*M*	*02/01/02*	*10*	*3*	*4*	*9*	*01*	*987654321*	*C5*							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A B C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a b c d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0024	*Osteoarthritis with motor score from 48-54, no comorbidity*	*A1203*					
0128	*Room & Board*	*1000.00*		*20*	*20000.00*	*20000.00*	
	PLUS Non-Covered Ancillary Revenue Codes & Charges						
0001	*Total Charges*				*XXXX.XX*	*XXXX.XX*	

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	*XXTXXX*					

57	DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
John Brokmahback	*01*	*123-45-6789A*		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
71515									*71515*		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID
A12345 DOCTOR, G. IMA
83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
IRF PPS CLAIM SAMPLE – BENEFITS EXHAUSTED PRIOR TO STAY	

85 PROVIDER REPRESENTATIVE	86 DATE
x Signature	Date

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

Billing Ancillary Services When Payment Cannot Be Made Under Medicare Part A

Payment may be made under Part B for the following medical and other health services when furnished by a participating rehabilitation hospital or an inpatient rehabilitation unit of a hospital to an inpatient of that hospital or unit when payment for these services cannot be made under Medicare Part A:

- Diagnostic X-Ray, laboratory, and other tests
- X-Ray, radium/radioactive isotope therapy, including materials/services of technicians
- Primary/secondary surgical dressings, splints, casts, and other devices used for reduction of fractures/dislocations
- Prosthetic devices
- Orthotic devices
- Inpatient dialysis services
- Speech, physical, occupational therapy
- Certain pharmacy items, limited to the following:
  - Pneumococcal Pneumonia/Flu Vaccine
  - Hepatitis B Vaccine
  - Immunosuppressive drugs furnished to organ transplant patients after a Medicare transplant procedure
- Oral cancer drugs

When coding IRF PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units, and Total Charges.

- Report the number of units based on the procedure or service

- Report the actual charge for each line item in Total Charges
- Report date of service for each line item ("line item date of service") with appropriate HCPCS coding

Patients Who Are Currently IRF Inpatients When the Transition to PPS Occurs

IRF Patients at Transition to IRF PPS

- **Clinical Staff Perform an Assessment Based on Characteristics of Beneficiary at Admission**
- **Claims can Cross Implementation**
- **Interim Claims Must be Cancelled**
  - **Submit a New Claim From Admission Through Discharge**

Clinical staff will perform an assessment based on the characteristics of the beneficiary at admission which will provide a HIPPS code for billing staff to use to prepare a regular claim.

Claims are allowed to cross over the date of transition because payment is based on the discharge date.

Since the final PPS payment is based on the discharge bill, all interim claims previously processed for a patient discharged after the implementation of IRF PPS must be cancelled using a 118 type of bill (cancel). After all cancelled claims have been adjudicated (finalized), one new claim must be submitted from admission through discharge using the appropriate IRF coding.

No special coding, other than IRF PPS coding, is required on a claim that crosses over the facility's transition date.

SPECIAL CLAIM SITUATIONS

Short Stays

Short Stays

- **Three Days or Less**
- **Bill Using HIPPS Code From Assessments**
- **Pricer at FI will Change HIPPS Code to A5001**

A short stay is an IRF inpatient stay of three days or less.

If the beneficiary discharges or expires during the first three days of the inpatient stay, that stay is deemed a short stay.

Short Stays are billed with the HIPPS code as created using the comorbidity tier and CMG code from the assessments. However, as a short stay claim is processing at the FI, the Pricer will change the HIPPS code to A5001. Payment will be made according to the new HIPPS code.

Patient Expires During Stay

Patient Expires During Stay

- **Bill Using HIPPS Code from Assessments**
- **Pricer at FI will Change HIPPS to One of the "Special" Codes**
  - **A5001**
  - **A5101**
  - **A5104**
  - **A5102**
  - **A5103**

When the beneficiary expires during an inpatient stay, a claim is billed with the HIPPS code as created using the comorbidity tier and CMG code from the assessments. However, as the claim is processing at the FI, the pricer will change the HIPPS code to one of the five special codes based on the situations listed below. Payment will be made according to the new HIPPS code.

The patient status must be 20 (expired) for any of these scenarios to apply.

- If patient expires during the 3-day admission assessment time period, CMG 5001 is assigned. The provider will never place HIPPS code A5001 on a claim.
- If a patient expires between Day 4 and Day 13 of the inpatient stay and is an orthopedic patient (RIC 07, 08, or 09), CMG 5101 is assigned. The provider will never place HIPPS code A5101 on a claim.
- If a patient expires between Day 4 and Day 15 of the inpatient stay and is NOT an orthopedic

patient, CMG 5103 is assigned. The provider will never place HIPPS code A5103 on a claim.

- If a patient expires 14 days or more into the inpatient stay and is an orthopedic patient (RIC 07, 08, or 09), CMG 5102 is assigned. The provider will never place HIPPS code A5102 on a claim.
- If a patient expires 16 days or more into the inpatient stay and is NOT an orthopedic patient, CMG 5104 is assigned. The provider will never place HIPPS code A5104 on a claim.